DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155298	B. WIN			07/19/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CAMBRII	DGE MANOR NURS	SING & REHABILITATION CENTE	R	1	OWNSHIP LINE RD APOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
		r a Recertification and	F0	000	Preparation and/or execution of this plan of correction in general,		
	State Licensure Survey.				or any corrective action does not		
					consittute an admission or		
	_	y 11, 12, 13, 14, 15, 18,			agreement by Cambridge Ma		
	and 19, 2011				Healthcare and Rehabilitation Center of the facts alleged on		
	T 11%	000105			conclusions set forthe in the	uic	
	Facility number:				statement of deficiencies. The		
	Provider number				Plan of Correction and specif		
	AIM number:	100267690			corrective actions are prepar and/or executed soley becau	se of	
	Survey team:				the provision of Federal or S	tate	
	Connie Landman	RN TC			laws.		
	Diana Zgonc RN						
	Christi Davidson						
	Courtney Hamilton						
	Census bed type:						
	SNF/NF: 92						
	Total: 92						
	Census payor typ	oe:					
	Medicare: 10						
	Medicaid: 62						
	Other: 20						
	Total: 92						
	Stage 2 Sample:	29					
	These deficiencie	es also reflect State					
		accordance with 410 IAC					
	16.2.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G77R11

Facility ID:

000195

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE :	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155298	B. WING			07/19/2	011
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				DWNSHIP LINE RD		
CAMBRII	OGE MANOR NUR	SING & REHABILITATION CENTER	₹		APOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Quality review co	ompleted 7/25/11					
	Cathy Emswiller	RN					
F0226 SS=C	The facility must d written policies and mistreatment, neg and misappropriate Based on record the facility failed policy with the preporting. This the potential to residents current facility.  Findings include An undated face "Abuse Protect Policy," provided on 07/11/11 at "VII. Reporting Issues:  1. POLICY: All alleged abuse wassessed to de the investigation.	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. It d review and interview, d to provide an abuse correct guidance on deficient practice had affect 92 of 92 antly residing in the e:  ility policy titled, ion and Response and by the Administrator 10:30 a.m., indicated, and And Response  Il reports of abuse or will be immediately termine the direction of n.	F0.	226	Element #1What corrective actions will be accomplished those residents found to have been affected by the deficient practices? It is the policy of the facility to see that all reports abuse/neglect or alleged abuse/neglect are reported immediately to the Administrator his/her designee. All such events will be thoroughly investigated. Further, the events of the ISDH within 2 hours of the event. The facilials does a 5 day follow up to the ISDH if all necessary reportable information was neavailable within the first 24 hours of the event. The facility is using the QIS manual's policy and procedu Abuse/Neglect reporting. Element of the process of the event of the process of the event of the same deficient paractice will be affected by the same deficient paractice will intertifications.	e t t t t t t t t t t t t t t t t t t t	08/18/2011
	2. PROCEDUR that substantiat alleged abuse of be reported immadministrator of representative a	RE: Any investigation res abuse or neglect or or neglect findings will mediately to the r his/her designated and to other officials in h State Law within 5			identified and what corrective actions will be taken? All residuate have the potential to be affect by this finding. Going forwar the staff will report any event abuse/neglect to their supervor the charge nurse, who will immediately notify the administrator or his/her designations.	dents eted d, e of visor	

000195

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298		(X2) MU  A. BUILI  B. WING	DING	OO	(X3) DATE S COMPL <b>07/19/2</b> (	ETED	
	PROVIDER OR SUPPLIED	IL R SING & REHABILITATION CENTI		STREET AL	DDRESS, CITY, STATE, ZIP CODE WNSHIP LINE RD APOLIS, IN46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	Administrator a designated repabuse policy la reflect the India Department wo 24 hours after incident.  During an inter 10:21 a.m., the indicated the p Protection and the current fac	cy lacked of reporting to the and/or his/her presentative, and the acked documentation to an a State Health buld be notified within discovery of the			so that the proper protocol cainitiated at once. Further, all events or alleged events will reported to the ISDH within 2 hours. All events of this type be listed by the charge nurse the 24 hour report so that the DON or designee can check see that all proper protocol will followed timely and accurately. Element #3What measures will be put into play what sytematic changes will make to ensure that the deficing practice does not recur? At an staff inservice held on Tuesd 8/9/2011, the policy and procedure on abuse/neglect reviewed. This includes the timely reporting of all events abuse/neglect and alleged abuse/neglect. The administ is to be immediately notified at the ISDH is to be notified with 24 hours. All points of the Q manual's abuse/neglect policy were reviewed and will be followed. Any staff who fail to comply with the points of the inservice will be further educand progressively disciplined appropriate. The facility has zero-tolerance policy in regard abuse/neglect or failure to resuch instances. Element #4H the corrective actions will be monitored to ensure the deficing practice will not recur. What quality assurance program we put into place? At the monthly Quality Assurance meeting a the tracking of the 24 hour resurred.	such be 4 will con to	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		ISTRUCTION 00	(X3) DATE S COMPL	
		155298	B. WIN		<u> </u>	07/19/2	011
	PROVIDER OR SUPPLIER	SING & REHABILITATION CENTE	R	8530 TO	DDRESS, CITY, STATE, ZIP CODE WNSHIP LINE RD APOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Έ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0241 SS=D	a manner and in a maintains or enha	romote care for residents in n environment that nces each resident's dignity			by the DON or designee will reviewed as well as all report abuse/neglect or alleged abuse/neglect to see that all reporting protocols have bee followed timely. Any concerr be immediately addressed. I necessary, an action plan wil written by a commitee appoin by the Administrator. This pl will be monitored weekly untiresolution. Again, no abuse/neglect or failure to resuch instances will be tolerate	nns will If Il be Inted	
	individuality. Based on obse and interview the respect the diggraph of the hallway for two sample of 2. Findings include The record for on 07/15/11 at Diagnoses included imited to aphase respiratory failures.	e: Resident #33 reviewed 1:58 p.m. uded, but were not sia and acute	F0	241	Element #1What corrective action(s) will be accomplishe those residents found to have been affected by the deficien practice?It is the policy of this facility to see that each reside care is administered in an environment of dignity and respect. Resident # 33 has dignity maintained at all time. Resident #33 does not have shirt raised to care for or wor with their feeding tube unless setting is completely private a dignified. Exactly what is to I done with the resident is explained to the resident prior the care being administered. Element # 2How other reside having the potential to be affeby the same deficient practic be identified and what correct action(s) will be taken?Any	e tt s ents s. their k s the and be ents ected e will	08/18/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155298 07/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8530 TOWNSHIP LINE RD CAMBRIDGE MANOR NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE "...unable to communicate..." resident who has a feeding tube has the potential to be affected by this finding. A targeted list was The most recent recapitulation dated made of all residents who have 07/01/11 through 07/31/11, indicated feeding tubes. All of these Resident #33 was NPO (nothing by residents who are interviewable were interviewed as to dignity mouth). concerns during care or use of their feeding tubes. Any The most recent recapitulation dated concerns were addressed. Going 07/01/11 through 07/31/11, with an forward, all residents with feeding original physician's order dated tubes will be monitored at least three days weekly during tube 06/23/11, indicated, "...All med per related care to see that dignity is G-tube and liquid where possible...." maintained. Any concerns will be addressed immediately. This The most recent recapitulation dated monitoring will be done by DON 07/01/11 through 07/31/11, with an or designee on various shifts and will continue until 4 consecutive original physician's order dated weeks of zero negative findings 05/24/11, indicated, "Jevity 1.5 cal are realized. Then, random (calories) at 60cc/hr (cubic centimeter weekly checks will continue. per hour) from 2pm - 10 am...." Element # 3What measures will be put into place or what systemic changes will be made to ensure A care plan title "Feeding Tube," that the deficient practice does dated 06/23/11 indicated, "Resident not reoccur?At an all staff has a need for use of a feeding inservice held 8/9/11 Resident tube...Resident will remain free of Rights and Dignity policies were reviewed. Special emphasis was complications related to use of a placed on maintaining dignity feeding tube...Check residual prior to during care and or use of a resuming any enteral feeding, (that feeding tube. Issues of draping, has been turned off for 1 hr or privacy, and unecessary skin greater)...Educate exposure were covered. Any staff who fail to follow the points resident/responsible party regarding of the inservice will be further feeding tube...Self-image." educated and or progressively disciplined as appropriate. During an observation on 07/14/11 at Element # 4How the corrective action(s) will be monitored to 1:35 p.m., LPN #14 asked CNA #15 ensure the deficient practice will

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	ILDING	NSTRUCTION  00	(X3) DATE COMPI 07/19/2	LETED
	PROVIDER OR SUPPLIER	I SING & REHABILITATION CENT	STREET A	DWNSHIP LINE RD APOLIS, IN46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	Е	(X5) COMPLETION DATE
	to bring the fee hall with Reside feedings could p.m.  During an obse 2:00 p.m., Resi hallway on the nurses station. and pole were The feeding tut to Resident #33 not running.  During an obse 2:35 p.m., LPN #33's shirt while hallway and co feeding to the Geeding to the Geedings.  During an interestance of the could p.m., LPN I shouldn't have taken him During an interestance asked him pole out with the could start the second p.m.  A current facility	ding pump out in the ent #33, so the tube be initiated at 2:00  Evation on 07/14/11 at dent #33 was in the second floor by the The feeding pump next to the resident. See was not connected 3, and the feeding was  Evation on 07/14/11 at #14 lifted Resident e he remained in the ennected the tube G-tube and started the entertain of		not reoccur, i.e., what qual assurance program will be into place? At the monthly of Assurance meetings the rethe feeding tube dignity monitoring will be reviewed concerns will have been addressed and corrected immediately upon discover	put Quality sult of	

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPL 07/19/2	ETED
	PROVIDER OR SUPPLIER	SING & REHABILITATION CENTE	8530 To	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, IN46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE .	(X5) COMPLETION DATE
	"8. Expose ( jejunostomy) to towel. NOTE: expose the Resplacement via a gastric/jejunal of syringe, re-instraspirated, or viauscultation of A current facility the Administration, titled, "Turent facility a.m., titled," Turent facility a.m., titled, "Turent facility faci	ejunostomy," indicated, 6/J (gastrostomy or ube and drape with Do NOT unnecessarily sident10. Verify tube aspiration of content with a feeding alling content a (by way of) air bolus"  y policy provided by or on 07/14/11 at 9:00 be Feeding Closed ol," indicated, "2. y and explain				

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	A. BUILDING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/19/2011
		133290	B. WING		01/19/2011
NAME OF F	PROVIDER OR SUPPLIER		ı	ET ADDRESS, CITY, STATE, ZIP CODE  TOWNSHIP LINE RD	
CAMBRII	DGE MANOR NUR	SING & REHABILITATION CENTE	R INDIA	ANAPOLIS, IN46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0272 SS=D	periodically a com standardized repro- each resident's fur A facility must mak assessment of a re	onduct initially and prehensive, accurate, oducible assessment of nctional capacity.  Ke a comprehensive esident's needs, using the ne State. The assessment			
	must include at lea	ast the following: demographic information; e; ;;			
	Psychosocial well- Physical functioning Continence; Disease diagnosist Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentian Documentation of regarding the additional continuation of the second	being; ng and structural problems; and health conditions; anal status; and procedures;			
	Based on obse record review to develop comple assessments for stage two samp (#88, #38) Findings includ	participation in assessment. rvation, interview and he facility failed to ete and accurate or 2 residents in a ole of 29 residents. e: for Resident #88 was	F0272	Element #1What corrective action(s) will be accomplished the those resdients found to been affected by the deficier practice? It is the policy of this facility to conduct initial and periodic assessments that all comprehensive and accurate revealing of the residents functional capacity in multiple specified areas. Resident # no longer resides. Resident #	have int is re e and e 88

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G77R11 Facility ID:

000195

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPI	LETED
		155298	1			07/19/2	011
		<u> </u>	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER	S.		1			
CAMPDI		CINIC 9 DELIADII ITATIONI CENT	-D	1	OWNSHIP LINE RD		
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CENTE	=K	INDIAN	APOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
	reviewed on 07	7/14/11 at 12:35 p.m.			has had a complete and the	-	
					assessment for dietary issu		
	Diagnoses incl	uded, but were not			which includes likes and dis		
	1 -	bral vascular accident,			Resident # 38 will continue		
					assessed periodically for dinneeds. Likes and dislikes a	-	
	hypertension, diabetes, osteoarthritis,				weight concerns will be incl		
	pain, and seizures.				Element # 2How other resid		
	A Resident Data Collection form,				having the potential to be a		
					by the same deficient practi		
		, indicated Resident			be identified and what corre	ective	
	#88 had mild pain in the left thigh, leg,				action(s) will be taken?All		
	and ribs. This	admission data			residents who have concern		
	indicated				pain or dietary issues could	be	
	Resident #88 h	ad pain on admission.			affected by this finding. A		
		lacked the assessment			"look-back" audit was done residents who receive pain	on all	
		ed to assess the			medications to be sure the	nain is	
					defined as much as possibl		
	irequency, inte	nsity or causes of pain.			to cause, intensity, frequen		
					and interventions to control	-	
		ed 05/10/11 indicated			pain. Periodic pain assessi	ments	
	a potential for p	pain related to			will continue on all residents	s who	
	osteoarthritis.	Interventions included			recieve pain medication to l		
	were, but not li	mited to, "Administer			certain appropriate interven	tions	
	medications as	orderedAssess for			are in place to keep pain		
		ge exerciseGentle			controlled and to improve lit quality for the resident. A	е	
	I -	nPT/OT (physical			"look-back" audit was done	facility	
	therapy/occupa	" ,			wide to see that all resdient	,	
		uonai inerapy)			had a recent (within last qua		
	evaluate"				dietary assessment that	,	
					addressess any dietary issu	ies	
	1 -	rapy note dated			including any concerns with		
	05/10/11 for ini	tial assessment,			weight loss or gain, open ar		
	indicated Resid	lent #88 has chronic			food preferences, special d		
	pain in left arm				needs and any other reside	nt	
	-				specific diet issues. All	bo	
	A physician's p	rogress note dated			necessary interventions will implemented to meet the di		
		ited Resident #88 had			need. Periodic assessmen		
	nain	TO TOUR TOU HAU			continue on all residents to		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155298	B. WIN			07/19/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2					
0.4400		0110 0 0511401117471011051			OWNSHIP LINE RD		
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CENTE	:K	I INDIAN	APOLIS, IN46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
			İ		assure all appropriate		
	A Pain Assessi	ment Sheet undated			intervientions are in place for	r any	
	and untimed, indicated Resident #88				dietary need that develops.		
					DON or designee will review	10	
		10 on the pain scale.			charts weekly to see that all		
		nt questions on the			appropriate assessments ha	ve	
	back of the pai	n assessment sheet			been done based on recent	4	
	were unanswe	red.			documentation in nurses no lab/x-ray results, falls, dietary		
					issues behaviors, skin issues		
	During an inter	view on 07/12/11 at			weight loss issues, or any ot		
	1	ident #88 indicated,			findings which would indicate		
		If the time from when I			need for an assessment to b		
	1 *	i the time from when i			done. If there is a needed		
	fell last year."				assessment, it will be comple	eted.	
	l				This monitoring will continue		
	During an inter				until 4 consecutive weeks of	zero	
	Administrator of	on 07/15/11 at 4:00			negative findings (all		
	p.m., documen	tation of a pain			assessments done as		
	assessment fo	r Resident #88 was			appropriate) are realized.		
	requested.				Afterwards, random weekly	ill bo	
					monitoring of assessments v done. Element # 3What	viii be	
	Op 07/19/11 a	t 2:00 p.m., the Charge			measures will be put into pla	ce or	
					what systemic changes will t		
		vided a copy of the pain			made to ensure that one def		
		eet, previously noted			practice does not reoccur?At		
	in the record, a	and the Resident Data			all staff inservice held 8/9/11	, the	
	Collection form	previously noted in			policy and procedure on		
	the record. No	further documentation			assessments was reviewed.		
	for a pain asse	ssment for Resident			following was discussed: a.		
	#88 was provid				do an assessment? b. When		
	"00 Hab provid				an assessment necessary?		
	An undeted for	sility policy provided by			Who can do an assessment		
		cility policy provided by			Assessment results as relaticate plan development. e.	<del>c</del> u io	
	the Administrator on 07/19/11 at 11:12 a.m. The Administrator indicated this				Assessments as related to M	1DS	
					process. f. DiscussionAny s		
				who fail to comply with the p			
	policy was the current policy for pain				of the inservice will be furthe		
	assessment.	he policy titled, "Pain			educated and or progressive		
	Management,"	indicated, "A			disciplined as necessary.Ele		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155298		LDING	00	COMPLETED 07/19/2011	
		100200	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	0771072011	႕
NAME OF F	PROVIDER OR SUPPLIER				OWNSHIP LINE RD		
		SING & REHABILITATION CENT	ER	1	APOLIS, IN46260		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	.
TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE	
_		essed for pain based			# 4How the corrective action(s)		$\neg$
	on: 1. Compla	int of pain			will be monitored to ensure t		
	communicated verbally. 2. Diagnosis		· · · · · · · · · · · · · · · · · · ·	deficient practice will not reo i.e., what quality assurance	occur,		
	of a condition k	nown to cause pain"			program will be put into place	<b>I</b>	
	The second page	ge of the policy			the monthly Quality Assurance meetings the assessment	ce	
	included a "Brie	ef Pain Inventory" form.			monitoring by the DON or		
	A blank Pain As	ssessment form was			designee will be reviewed. A patterns will be identified. If	Any	
	provided with the	ne policy.			necessary, an action plan wi	ll be	
	<b>#2.</b> Residenti#38	's record was reviewed			written by a committee appoint	<b>I</b>	
	on 07/14/2011 ati	12:35 P.M Diagnoses			by the administrator. The pla will be monitored by the	an	
	included buti were	e noti limitied tio lefi			administrator weekly until		
	parotitis, multiple	sclerosis,			resolution.		
	ostieoartihritisdep	pression, and a					
	non-healing righti	ankle ulcer					
	A currenti physicia	ans order datied					
	06/13/2011 indica	atied residenti was tio					
	receive a mechani	cal sofi dieti witih					
	regular liquids and	d tiube fieeds af 5					
	millilitiers/hour fire	om7 P.M. tio5 A.M.					
	An intierview witil	h residen#38 on					
	07/15/2011 ati1:2	5 P.M. indicatied tihe					
	fiacilitiy had never	asked her whati her					
	·	wereShe indicatied tihe					
		ry good and she did noti					
		ks she was served She					
	had consumed 259	% оп tihe meal.					
	A current care plan updated						
		cated "resident					
	remains at risk	for unplanned weight					

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155298	B. WIN			07/19/2	UII
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CAMBRII	DGE MANOR NUR	SING & REHABILITATION CENT	ED	1	DWNSHIP LINE RD APOLIS, IN46260		
			LIN	<u> </u>	AI OLIO, IIV <del>1</del> 0200		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ.	DATE
		% of meals uneaten."		-			
		icluded "honor food					
	preferences."						
	·						
	Food intake red	cords for June 2011					
	indicated resident consumed on						
	average 50% o	f most meals.					
		tion therapy monthly					
	review dated 06	6/10/2011 indicates					
		I receive pleasure					
	foods. The reco						
	documentation	<u> </u>					
		resident #38's likes or					
	dislikes.						
	^ - :-t:	th the Dietem Menenga					
		th the Dietary Manager at 1:10 P.M. indicated					
		ietary assessment					
		r to 07/18/2011.					
	completed pho	1 10 077 10/2011.					
	A current facility	policy dated 2008,					
		Administrator 07/19/2011					
	1	tled, "Medical Nutrition					
		entation" indicated "					
	initial assessmen						
		food preferences"					
	mioimution on	1000 protototioos					
	3.1-31(b)						
	5.1 51(0)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155298	B. WING			07/19/2	011
			B. 11111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				DWNSHIP LINE RD		
CAMBRII	DGE MANOR NUR	SING & REHABILITATION CENTE	R		APOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279	A facility must use						
SS=D		velop, review and revise the					
	resident's comprei	hensive plan of care.					
	The facility must d	evelop a comprehensive					
	-	resident that includes					
	•	tives and timetables to meet					
		al, nursing, and mental and					
	psychosocial needs that are identified in the						
	comprehensive as	ssessment.					
		at describe the conject that					
		st describe the services that					
are to be furnished to attain or maintain the resident's highest practicable physical,							
		osocial well-being as					
	required under §4	83.25; and any services that					
	would otherwise b	e required under §483.25					
	•	ed due to the resident's					
		under §483.10, including the					
		itment under §483.10(b)(4).	F0/	370	Floment # 1\M/bat corrective		00/10/2011
		review and interview the	F0.	279	Element # 1What corrective action(s) will be accomplished for		08/18/2011
	-	ensure care plans were			those residents found to have		
	•	sidents with pressure			been affected by the deficien		
		ties of daily living for 2			practice?It is the policy of this		
	of 29 residents re	eviewed for care plans			facilty to see that all resident		
	(Resident # 59, #	440)			have a comprehensive plan of	ΣT	
					care based on the result of accurate and timely		
	Findings include	:			assessments.Resident # 59		
					currently has a care plan whi	ch	
	1 A current und	ated facility policy titled			addressess their skin issues	and	
	"Care Plan" and				has appropriate interventions		
		17/19/11 at 11:00 A.M.			place to promote healing of s	kin	
	indicated,	1 // 1 // 11 at 11.00 A.ivi.			and improve quality of life. Resident # 40 currentlly has	2	
	,	Sana Dian			care plan which addressess		
	"Purpose of the Care Plan An interdisciplinary Care Plan provides the guidance to all staff caring for the				ADLs (Activities of Daily Livir		
					All appropriate interventions		
					in place to promote as much		
	resident and com	municates changes in			independence and well-being		
					possible for the resident. Ele	ment	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155298		LDING	<del></del>	07/19/2	011
		1.0000	B. WIN				
NAME OF I	PROVIDER OR SUPPLIE	R		1	ADDRESS, CITY, STATE, ZIP CODE		
				1	OWNSHIP LINE RD		
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CENT	ER	INDIAN	APOLIS, IN46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIE.	DATE
	care to all direct	care staff.			# 2How other residents hav	ing	
	An interdiscipli	nary approach to			the potential to be affected I	by the	
	1				same deficient practice will		
	identification of problems and developing				identified and what corrective	e e	
	solutions and goals provides				action(s) will be taken?All		
	individualization and coordination of				residents have the potential		
	resident care.				affected by this finding. A 3	•	
	Policy				" look-back" audit was done facility wide on all residents		
	All residents must have a Care Plan.				certain any skin concerns of		
	Updating Care Plan				(Activity of Daily Living) con		
	1 ^ ~				are care planned. Any cond		
	1	inary Care Plan is			will be addressed immediate		
		ed and updated quarterly			Theses monitorings will con		
	and more freque	ently if warranted by a			until 4 consecutive weeks o	f zero	
	change in reside	ent's condition.			negative findings are realize	ed.	
	_	sident Care Plan			Afterwards, random weekly		
	1	e plan is initiated at the			monitorings be done. Elem		
	time of admission	•			3What measures will be put		
	time of admission	OII.			place or what systemic char	-	
	. The mean of	for Docident # 50			will be made to ensure that	tne	
		for Resident # 59 was			deficient practice does not reoccur?At an all staff inser	viao.	
		ecord review 7/18/11 at			held 8/9/11 the importance		
	1:00 P.M.				comprehensive care plan ba		
					on assessments was discus		
	The resident w	as admitted on 6/3/11			The care plan policy was		
	with pressure	ulcers.			reviewed. Emphasis was p	aced	
					on the need for care plans v	vith	
	Diagnoses for	Resident # 59 included			appropriate interventions for	-	
		mited to decubitus			skin issues or ADL needs of	•	
					resident. Any staff who fail		
	1	cemia, Diabetes and			comply with the points of the		
	respiratory fail	ure.			inservice will be further edu		
					and or progressivley discipli as appropriate.Element # 4I		
	The admission assessment of 6/3/11				the corrective action(s) will l		
	indicated the r	esident had pressure			monitored to ensure the def		
	ulcers on both heels, right lateral				practice will not reoccur, i.e.		
		coccyx/sacral area.			quality assurance program		
		coognication.			put into place;?At the month		
					Quality Assurance meetings		

l í		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155298	B. WIN	NG		07/19/2	011
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
0.4455		0,			OWNSHIP LINE RD		
CAMBRII	DGE MANOR NUR	SING & REHABILITATION CENT	ER	INDIAN	APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	,	<b>.</b>	DATE
		ked documentation of			monitoring results of the DO designee as related to care		
		plan or current care			and ADLs will be reviewed.		
	plans that indicated interventions,				patterns will be identified. If	•	
	l •	s resolved or any new			necessary, an action plan wi		
	·	atments for Resident			written by a committee appo		
	#59's pressure	ulcers.			by the administrator. The plus will be monitored weekly unt		
					resolution.		
		view with the 3rd floor					
		/11 at 2:35 P.M., care					
	plans for the resident's pressure ulcers were requested.						
	_	view with the 3rd floor					
		/11 at 3:30 P.M. she					
		were care plans but					
		ind the originals so she					
	redid them.						
	#3. Resident #40	's record was reviewed					
	on 07/15/2011 at	9:20 A.M Diagnoses					
	included but wer	re not limited to					
	hypertension, exp	pressive aphasia, vascular					
	dementia, dyspha	agia, coronary artery					
	disease, and psor	riasis.					
	_						
	A current care pl	an last updated					
	_	eated "potential for					
		lated to dx {diagnosis) of					
	1 1	diseaserisk for decline in					
		s of daily living]"					
	Approaches liste						
		lated to coronary artery					
		ord lacked documentation					
	uisease. The fect	oru rackeu uocumentation					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155298			(X2) MU A. BUILI B. WING	DING	00	(X3) DATE S COMPL 07/19/2	ETED
	PROVIDER OR SUPPLIER	SING & REHABILITATION CENTE	R	8530 TC	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	decline in ADL's	address the residents . h CNA #1 on 07/15/2011					
		dicated resident is able face but she is dependent DL's.					
07/18/2011 at was no ADL o		h the DON on 30 A.M., indicated there e plan and stated that ould have one.					
	3.1-35(b)(1)						
F0282 SS=D	facility must be pro in accordance with plan of care.	ded or arranged by the ovided by qualified persons n each resident's written					
	Based on observation, interview and record review the facility failed to ensure physician orders were followed for the use of side rails and medication administration. This affected 2 of 29 residents reviewed for physician orders in a sample of 29. (Resident #38, Resident #39)  Findings include:		F02	282	Element # 1What correct act will be accomplished for thos residents found to have been affected by the deficient practice? It is the policy of the facility to see that services ar provided by qualified persons accordance with the resident plan of care. Currently reside 38 has the use of side rails a physician order, assessment care plan. Currently resident receives all medications as p	eeen eees in es sin es sent # es per , and t # 39	08/18/2011
	#1. Residenti#38 ' : 07/14/2011 ati12:3	s record was reviewed on 5 P.M Diagnoses			physican order. These medications have all be clarit with the physican. Currently resident # 38 has the use of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155298 07/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8530 TOWNSHIP LINE RD CAMBRIDGE MANOR NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE included buti were noti limitied tio lefi bed, matts, and tubular bolsters on bed. This is per physican parotitis, multiple sclerosis, ostieoartihritis order and assessment. Element depression, and a non-healing righti ankle # 2How other residents having the potential to be affected by the same deficient practice will be A current physicians order dated identified and what corrective action(s) will be taken?All 05/26/2011 indicated resident was to resdients have the potential to be have "...full side rails both sides..." affected by these findings. A facility wide audit was completed A care plan updated 05/28/2011 to be certain that all residents who have orders for siderails indicated the use of full side rails. have an assessment in place which indicates a medical need A current multidisciplinary therapy for the siderail. Further, if the screening dated 06/27/2011 indicated resident does have an order and resident is non compliant with asking medical need for a siderail(s) this is care planned and monitored for help and requires a low bed, per policy and state/federal alarms and mats. The record lacks regulations. The facility tries to documentation of the presence of use siderails only when absolutely side rails. necessary due to safety concerns.All residents were audited to see if they were using Observation of resident #38's room on siderails. If they were, all the following dates: protocols were completed per 07/11/2011-07/15/2011 indicated policy and state/federal resident did not have full side rails on regulations. Any concerns were the bed. addressed. A facility wide audit was completed to ensure that all residents were receiving all of the The record lacked documentation of a medications ordered for them. physicians order to discontinue the Any concerns were immediately side rails. addressed. The DON or designee will monitor 10 charts weekly to see that siderail useage or An interview with the DON on non-usage is corrected and being 07/18/2011 at 9 A.M., indicated the implemented only per facility had been working hard to policy/procedure. Also, 10 charts discontinue the use of side rails and will be monitored to see that all medications are being had done so for several residents in

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155298 07/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8530 TOWNSHIP LINE RD CAMBRIDGE MANOR NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE administered according to current the facility. She indicated there was physican orders. Any concerns no physicians order to discontinue the found on these monitorings will side rails. be immediately corrected. These monitorings will continue until 4 2. The record of Resident #39 was consecutive weeks of zero reviewed on 07/18/11 at 5:00 p.m. negative findings are reallized. Afterwards, random weekly checks will be done. Element # Diagnoses included were, but not 3What measures will be put into limited to, hypertension, dementia place or what systemic changes with delusions, chronic renal will be made to ensure that the insufficiency, and osteoarthritis. deficient practice does not reoccur?At an all staff inservice held 8/9/11 the policy A current recapitulation dated and proceedure for siderails was 07/01/11 through 07/31/11, with a reviewed. The following was physician's order with an original date covered: a. Siderail safety b. Siderail order (what, where, of 06/03/11, indicated, "Metoprolol when) c. Siderail assessment/ Tartrate (hypertension medication) care plan d. Medical need e. 25mg Tab...Give 1 tablet by mouth Consent/ Waiver f. Flow sheet g. twice daily...." CNA assignment sheet h. Education on siderails (resident and family) i. DiscussionAlso at A Medication Administration Record the inservice the necessity of (MAR) dated 07/01/11 through administering only ordered 07/31/11 indicated Resident # 39 was medications and all ordered scheduled to receive Metoprolol medications was reviewed. The Tartrate 25mg at 9:00 a.m. daily. policy and procedure for taking a medication order was reviewed. This includes: a). Receiving During a medication observation on order b). Checking 07/15/11 at 9:00 a.m., LPN #12 did allergies c). Placing on not administer Metoprolol Tartrate medication sheet/treatment 25mg at 9:00 a.m. to Resident #39. sheet d). Ordering medication e). Following up on meedication f). Proper A MAR dated 07/01/11 through notifications q). Stop date (if 07/31/11 indicated the last dose of known) h). Discontinuance of a Metaprolol Tartrate 25mg was given at medication i). Returning 9:00 a.m. on 07/10/11. The MAR has medications if appropriate j).

000195

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155298	B. WIN			07/19/2	011
		<u> </u>	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	DWNSHIP LINE RD		
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CENT	-R	1	APOLIS, IN46260		
					7.11 02.10, 11.1102.00		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG		otual	DATE
	_	the date 07/11/11 and a			Destruction of medication (a medication on MAR) k).	cluai	
		te, "SEE NEXT PAGE			DiscussionAny staff who fail	to	
		ERS ORDE {SIC}"			comply with the points of this		
	Page two or pa	age three of the current			inservice will be further educ		
	MAR did not ha	ave the medication			and or progressively discipling		
	listed. Yellow I	nighlight was drawn			as appropriate. Element # 4H		
	over Metaprolo	ol Tartrate 25mg.			the corrective action(s) will b		
	•	Ç			monitored to ensure that def practice will not reoccur, i.e.,		
	During an inter	view on 07/18/11 at			quality assurance program w		
	_	I #13 indicated she was			put into place;?At the month		
	•				Quality Assurance meetings		
	not aware of why the medication had				results of the siderail and		
	not been given. She indicated it appeared discontinued because of				medication adminstration		
	• •	Diffillitued because of			monitoring by the DON or		
	the highlight.				designee will be reviewed. A	Any	
					concerns will have been	nv.	
	_	view on 07/18/11 at			corrected upon discovery. Any patterns will be addressed. If		
	•	second floor ADoN			necessary, an action plan wi		
	indicated she v	vas not aware of why			written by a committee appo		
	the medicine a	ppeared to be			by the administrator. The pla	n will	
	discontinued.				be monitored weekly by the		
					administrator until resolution		
	During an inter	view on 07/18/11 at					
	_	DoN indicated she					
	•	ate the issue of the					
	medication.						
	Δ new nhyeicia	in's order dated					
		8 p.m., indicated an					
		•					
		on for Metaprolol					
	Tartrate 25mg	for Resident #39.					
	3.1-35(g)(2)						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		A. BUILDING 00 COMPL		(X3) DATE SURVEY COMPLETED 07/19/2011				
	PROVIDER OR SUPPLIER	SING & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE  8530 TOWNSHIP LINE RD  INDIANAPOLIS, IN46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F0309 SS=D	must provide the reto attain or maintal physical, mental, a in accordance with assessment and physical physical physical followed or the affected 1 of 29 for side rails in (Resident #38)  Findings included having the parotitis, multiple side parotitis, multiple side pression, and a nulcer.	rvation, interview and the facility failed to an orders were use of side rails. This presidents reviewed a sample of 29 ce:	F0309	Element # 1What corrective action(s) will be accomplished those residents found to have been affected by the deficier practice? It is the policy of the facilty to see that all resident receive the necessary care at treatment to maintain the hig level of overall well-being. Currently Resident # 38 has use of low bed, matts, tubula bolsters, on bed. This is perphysican order and assessments. Element # 2Ho other residents having the potential to be affected by the same deficient practive will be identified and what corrective action(s) will be taken? All resdients have the potential affected by these findings. A facility wide audit was complited to be certain that all residents.	e this s and chest the ur www.e e be e to be A eted			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155298	B. WIN			07/19/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	DWNSHIP LINE RD		
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CENTE	R	1	APOLIS, IN46260		
				L	711 0210, 11410200		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
IAG	<del>                                     </del>	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
have "full side rails both sides"					who have orders for siderails have an assessment in place		
					which indicates a medical ne		
	A care plan updated 05/28/2011				for the siderail. Further, if the		
	indicated the u	se of full side rails.			resident does have an order		
					medical need for a siderail(s)		
	A current multion	disciplinary therapy			is care planned and monitore		
		d 06/27/2011 indicated			per policy and state/federal		
		compliant with asking			regulations. The facility tries		
		quires a low bed,			use siderails only when abso	lutely	
	•	ts. The record lacks			necessary due to safety concerns.All residents were		
					audited to see if they were us	sina	
		of the presence of			siderails. If they were, all	Sirig	
	side rails.				protocols were completed pe	er	
					policy and state/federal		
	Observation of	resident #38's room on			regulations. Any concerns w	ere	
	the following da	ates:			addressed.A facility wide aud		
	07/11/2011-07/	15/2011 indicated			was completed to ensure tha		
	resident did no	t have full side rails on			residents were receiving all o		
	the bed.				medications ordered for then Any concerns were immediated		
					addressed.The DON or design	-	
	The record lack	ked documentation of a			will monitor 10 charts weekly		
		er to discontinue the			see that siderail useage or		
	side rails.	er to discontinue the			non-usage is corrected and b	peing	
	Side rails.				implemented only per		
	A i t i	State the a DONLara			policy/procedure. Also, 10 c		
	An interview w				will be monitored to see that	all	
		9 A.M., indicated the			medications are being administered according to cu	ırrent	
		en working hard to			physican orders. Any conce		
		e use of side rails and			found on these monitorings v		
	had done so fo	r several residents in			be immediately corrected. T		
	the facility. She	e indicated there was			monitorings will continue unt		
	no physicians	order to discontinue the			consecutive weeks of zero		
	side rails.				negative findings are reallize	d.	
					Afterwards, random weekly		
	3.1-35(g)(2)				checks will be done. Elemer 3What measures will be put	-	
					place or what systemic chan		
					will be made to ensure that the	-	
						-	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	A. BUILDING  B. WING	00	(X3) DATE SURVEY  COMPLETED  07/19/2011		
	ROVIDER OR SUPPLIER	  -  SING & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE  8530 TOWNSHIP LINE RD				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5)  COMPLETION DATE		
				deficent practice does not reoccur? At an all staff inse held 8/9/11 the policy and proceedure for siderail reviewed. The following was covered: a. Siderail safety Siderail order (what, where when) c. Siderail assessm care plan d. Medical need Consent/ Waiver f. Flow sl CNA assignment sheet h. Education on siderails (resi and family) i. DiscussionAl the inservice the necessity administering only ordered medications was reviewed. policy and procedure for tamedication order was reviewed. This includes: a). Receiving allergies c). Placing on medication sheet/treatment sheet d). Ordering medication e). Following uneedication f). Proper notifications g). Stop date known) h). Discontinuance medication i). Returning medication i). Returning medication of medication (medication on MAR) k). DiscussionAny staff who facomply with the points of the inservice will be further educand or progressively discip as appropriate. Element # 4 the corrective action(s) will monitored to ensure the depractice will not reoccur, i.e. quality assurrance program be put into place;? At the m	rvice s was as b. d, ent/ e. neet g. ident so at of d The king a wed. g  t p on (if e of a ). actual iil to nis ucated lined l-How be ficient e., what n will		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE  A. BUILDING  B. WING	CONSTRUCTION  00	(X3) DATE S COMPLE 07/19/20	ETED	
	PROVIDER OR SUPPLIER	SING & REHABILITATION CENTE	8530	T ADDRESS, CITY, STATE, ZIP CODE TOWNSHIP LINE RD ANAPOLIS, IN46260	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0322 SS=D	a resident, the factoresident who is fed gastrostomy tube treatment and service pneumonia, diarrh metabolic abnormasal-pharyngeal possible, normal education before administration of a stage two services. Findings including the record for 1 of 7/15/11 at 1 of 1/15/11 at 1/15/	ulcers and to restore, if lating skills.  rvation, record review the facility failed to ant or gastric residual tering tube feedings rostomy tube (G-tube) tents with G-tubes out sample of 29. (#33)  e:  Resident #33 reviewed 1:58 p.m.  uded, but were not	F0322	Quality Assurance meeting results of the siderail and medication adminstration monitoring by the DON or designee will be reviewed. concerns will have been corrected upon discovery. patterns will be addressed. necessary, an action plan written by a committee appropriate the administrator. The plus be monitored weekly by the administrator until resolution.  Element # 1What corrective action(s) will be accomplish those residents found to habeen affected by the deficie practice? It is the policy of the facility to see that a resident by the feeding tube receive appropriate treatment and services to avoid any complications. Currently, Refarming the properties of the prior to any administration of the prior to an	Any If vill be pointed an will an will an the control of for the control of food ment # g the he be we the	08/18/2011

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155298	A. BUI B. WIN	ILDING NG		07/19/2	011
		<u> </u>	D. ((1)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	R		8530 TC	DWNSHIP LINE RD		
		SING & REHABILITATION CENT	ER	<u> </u>	APOLIS, IN46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION)	+	IAG	•	o fod	DATE
	respiratory fail	ure.			finding. All residents who are by tube will be monitored at I		
	A Consider Operation Decreases and details				3 times weekly on various sh		
	1	ce Progress note dated			to be sure all protocol is follo		
	1	ated Resident #33,			related to adminstration of		
	"unable to co	ommunicate"			medications or feeding via tu		
					This monitoring will be done	by	
	The most rece	nt recapitulation dated			the DON or designee. It will continue until 4 consecutive		
	07/01/11 throu	gh 07/31/11, indicated			weeks of zero negative findir	nas	
	1	vas NPO (nothing by			are realized. Any concerns r	-	
	mouth).	( 3 )			at the time of the monitorings		
	,				be corrected on site. Afterwa	ards,	
	The most recent recapitulation dated				random weekly monitorings	will	
	07/01/11 through 07/31/11, with an				continue.Element # 3 What		
	original physician's order dated				measures will be put into pla		
	1				what systemic changes will be made to ensure that the deficient		
	1	ated, "All med per			practices does not reoccur?		
	G-tube and liqi	uid where possible"			all staff inservice held 8/9/11	the	
	The most rece	nt recapitulation dated			policy/procedure on tube fee was reviewed. Checking	aings	
	1	gh 07/31/11, with an			placement of the tube prior to	,	
	1	ian's order dated			adminstration of feeding or		
	1	ated, "Jevity 1.5 cal			medications was discussed.	Any	
	1	cc/hr (cubic centimeters			staff who fail to comply with t		
	1 ' '	2pm - 10 am"			points of the inservice will be		
		2pm - 10 am			further educated and or		
	A core plan titl	o "Fooding Tube "			progressively disciplined as appropriate.Element # 4How	the	
		e "Feeding Tube,"			corrective action(s) will be	uic	
	1	indicated, "Resident			monitored to ensure the defice	cient	
	1	use of a feeding			practice will not reoccure, i.e	.,	
		t will remain free of			what quality assurance progr	am	
	<u> </u>	related to use of a			will be put into place;?At the		
		Check residual prior to			montly Quality Assurance	ıhe	
	resuming any	enteral feeding, (that			meetings the results of the tu feeding monitoring by the DC		
	has been turne	ed off for 1 hr or			designee will be reviewed. A		
	greater)Educ	cate			patterns will be identified. If	,	
	1 -	nsible party regarding			necessary, an action plan wi		
					written by a committee appoin	nted	

000195

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE  A. BUILDING  B. WING	00	COM	TE SURVEY IPLETED 0/2011		
	PROVIDER OR SUPPLIER	IL SING & REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE  8530 TOWNSHIP LINE RD				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Self-image "	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  by the administrato	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
	1:35 p.m., LPN to bring the fee hall with Reside feedings could p.m.  During an obse 2:00 p.m., Resi hallway on the nurses station. and pole were The feeding tut to Resident #3: not running.  During an obse 2:35 p.m., LPN #33's shirt while hallway and co feeding to the 0 feedings. LPN placement of the check for gastricture. PN I shouldn't have taken him When asked we checking for resident with the sked we checking for resident with the sked we checking for resident with the sked we checking for resident product the sked we checking for resident with the sked we checking for resident product the sked we check the sked	ervation on 07/14/11 at II #14 asked CNA #15 ding pump out in the ent #33, so the tube be initiated at 2:00 ervation on 07/14/11 at ident #33 was in the second floor by the The feeding pump next to the resident. De was not connected 3, and the feeding was ervation on 07/14/11 at #14 lifted Resident e he remained in the nnected the tube G-tube and started the #14 did not check he G-tube and did not		by the administrator will be monitored we resolution.			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	COMPL	ETED	
		155298	B. WIN			07/19/2	U11
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE  DWNSHIP LINE RD		
CAMBRII	DGE MANOR NURS	SING & REHABILITATION CENT	ER	INDIAN	APOLIS, IN46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	knew the importance of checking for placement and residual prior to initiating tube feedings through a G-tube.						
	10:55 a.m., CN nurse asked hir pole out with th	view on 07/15/11 at A #15 indicated the m to bring the feeding e resident so they tube feedings around					
	the Administrate a.m., titled, "Tu Gastrostomy/Je"8. Expose G (gastrostomy/je drape with towe unnecessarily experiences a resident10. via aspiration of content with a fre-installing corr (by way of) aus bolus"	ejunostomy," indicated, 6/J ejunostomy) tube and el. NOTE: Do NOT expose the Verify tube placement of gastric/jejunal eeding syringe, intent aspirated, or via					
	a.m., titled, "Tu	be Feeding Closed ol," indicated, "2. and explain					
	3.1-44(a)(2)						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

00	(X3) DATE SURVEY COMPLETED 07/19/2011
TOWNSHIP LINE RD	
PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Ī	T ADDRESS, CITY, STATE, ZIP CODE TOWNSHIP LINE RD NAPOLIS, IN46260  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE

STATEMENT OF DEFICIENCIES (X1) PR		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DIVI	DDIC	00	COMPL	ETED
		155298	A. BUII			07/19/2	011 l
			B. WIN		DDDDGG GYMY GWAR GYD GODD		
NAME OF P	ROVIDER OR SUPPLIER	L		l	ADDRESS, CITY, STATE, ZIP CODE		
0.4.4.0.0.1		0,		l	OWNSHIP LINE RD		
CAMBRIL	JGE MANOR NUR	SING & REHABILITATION CENTE	:K	INDIAN	APOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0334		levelop policies and					
SS=E	procedures that er						
		the influenza immunization,	1				
		the resident's legal					
	•	eives education regarding					
	•	otential side effects of the					
	immunization;	s offered an influenza					
		bber 1 through March 31					
		ne immunization is medically					
		the resident has already					
		during this time period;					
		r the resident's legal					
	representative has	s the opportunity to refuse					
	immunization; and	l ·					
		medical record includes					
		at indicates, at a minimum,					
	the following:						
		dent or resident's legal					
	•	s provided education					
		efits and potential side					
		a immunization; and dent either received the					
	· ·	ation or did not receive the					
		ation due to medical					
	contraindications						
	oonaamaraaanono (	or roladal.					
	The facility must d	levelop policies and					
	procedures that er						
	(i) Before offering	the pneumococcal					
	immunization, eac	th resident, or the resident's					
		e receives education					
		efits and potential side					
	effects of the imm	•					
		s offered a pneumococcal					
		ess the immunization is					
	already been imm	dicated or the resident has					
		unized; r the resident's legal					
		s the opportunity to refuse					
	immunization; and						
		medical record includes					
	, ,		1				I I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155298 07/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8530 TOWNSHIP LINE RD CAMBRIDGE MANOR NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. Element # 1What corrective F0334 08/18/2011 action(s) will be accomplished for Based on record review and interview those residents found to have the facility failed to ensure annual been affected by the deficient consents for influenza vaccinations practice?It is the policy of this were obtained prior to administration facility to see that all residents/legal representatives of annual flu vaccines for 4 of 5 are educated as to the side residents reviewed for flu vaccination effects of any immunization to be consents (Residents #19, #85, #84, given including that for flu. These #9), and failed to administer flu flu immunizations offered October vaccine for 2 of 5 residents reviewed 1st thru March 31st. The resident or legal guardian may refuse. for flu vaccine administration in a The resident's record will reflect Stage 2 sample of 29 (Residents #9 this education and administration and #40). or refusal. The same is true for pneumococcal immunizations. Findings include: Except this isn't necessarily recommended October 1st thru March 31st and is not annual but An undated, current facility policy, every 5 years. Residents # 19, provided by the Administrator on #85, #84, and #9 have had 7/19/11 at 11:00 A.M., titled consents obtained appropriately

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

G77R11

Facility ID:

000195

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155298	A. BUI	LDING	00	07/19/2	
		133290	B. WIN			0771972	011
NAME OF I	PROVIDER OR SUPPLIEI	₹			DDRESS, CITY, STATE, ZIP CODE		
CAMPDI		CINIC & DELIABILITATION CENT	-D	1	OWNSHIP LINE RD		
CAMBRI	DGE MANOR NUR	SING & REHABILITATION CENT	EK	INDIAN	APOLIS, IN46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·	0 1	DATE
		rogram" indicated:			for flu vaccine. Residents # # 40 will receive flu vaccine a		
		protect residents			time the physican orders it to		
	_	za virus by our annual			given. Also,, they will receive		
	flu vaccine pro	_			pneumonia vaccine as		
	Procedure -	All residents			well.Element # 2How other		
	receiving the ir	nfluenza vaccine:			residents having the potentia		
	will have the	vaccine recorded on			be affected by the same defi-		
	their Health red	cord History Form			practice will be identified and what corrective action(s) will		
		ceiving an Influenza			taken?All residents have the		
		ve a signed consent			potential to be affected by the		
		edical record"			finding. A spreadsheet has b		
		5 d. 5 d			created to be sure all resider		
	On 7/18/11 at	10:00 A.M., the			have the required education	and	
		ents' records were			offer of all proper vaccines		
		nnual flu consents and			including those for flu and pneumonia. Consent forms	azill	
					be part of this process. Any	vvIII	
	immunizations				resident who has an order fo	r flu	
		the Immunization			or pneumonia immunizations		
		ed he had refused both			who desires them to be given	n will	
	•	eumonia vaccines. The			receive them (unless		
		a signed refusal or			contraindicated due to a med		
	consent form.				reason). This will be moniton		
	Resident #85,	received a flu			monthly by the DON or design Residents will be added to the		
	vaccination on	3/13/11. The record			"tracker file" spreadsheet up		
	lacked docume	entation of a signed			admission. This monitoring		
	consent.	-			be ongoing. Element # 3Wha		
	Resident #84 r	eceived the flu vaccine			measures will be put into pla		
		The record lacked			what systemic changes will be		
		of a consent for flu			made to ensure that the defice practice does not reoccur? At		
	vaccination.				all staff inservice held 8/9/11		
		record lacked an			necessity of all appropriate		
	Immunization F				immunizations was reviewed	l.	
		,			The process of education,		
	documentation				consent, and administration		
	administration,				discussed. Any staff who fai		
		of consent for the flu			comply with the points of this inservice will be further educ		
	vaccination.				inservice will be further educ	ateu	

AND PLAN OF CORRECTION IDENTIFICATION NUMB		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		NSTRUCTION 00	(X3) DATE S COMPL	ETED
		155298	B. WING	G		07/19/2	011
	PROVIDER OR SUPPLIEF	SING & REHABILITATION CENTE	- R	8530 TC	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	$\overline{}$	ID I			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
TAG	Resident #40's consent form wanted the fluvaccines admin 10/30/10. The documentation fluor pneumor During an intervadministrator of he indicated Rereceive the vacuum pluring an interval (Director of Nu 10:30 A.M., shift with the DON also unable to deterve the pon the flutime, the DON	record had a signed which indicated she and pneumonia nistered, signed on record lacked of administration of a nia vaccine.  view with the on 7/19/11 at 8:30 A.M., resident #40 did not occines, the facility's		TAG	and or progressively disciplin as appropriate. Element # 4h the corrective action(s) will be monitored to ensure the defic practice will not reoccur, i.e., quality assurance program we put into place;? At the month of Quality Assurance meetings results of the monthly immunization "tracker file" spreadsheet monitoring by the DON or designee will be reviewed. Any concerns will addressed. Any patterns will identified. If necessary, an aplan will be written by a committee appointed by the administrator. The plan will be monitored weekly by the administrator until resolution.	led How e cient what fill be y the be be ction	DATE

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  07/19/2011		
NAME OF PROVIDER OR SUPPLIER  CAMBRIDGE MANOR NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  8530 TOWNSHIP LINE RD INDIANAPOLIS, IN46260				
		TATEMENT OF DEFICIENCIES	ID	, ii OE10, ii 10200	(VI)		
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE		
F0425 SS=D	residents, or obtain described in §483. facility may permit administer drugs if under the general nurse.  A facility must proviservices (including accurate acquiring administering of all meet the needs of The facility must e of a licensed pharm consultation on all pharmacy services Based on observate facility failed to expired in 2 of 5 for expired medical findings include A current facility	and biologicals to its in them under an agreement in 1.75(h) of this part. The unlicensed personnel to if State law permits, but only supervision of a licensed  wide pharmaceutical grocedures that assure the in, receiving, dispensing, and ill drugs and biologicals) to each resident.  Imploy or obtain the services macist who provides aspects of the provision of is in the facility. In ation and interview the ensure insulins were not medication carts checked cations.  In policy dated 10/07 and on Storage" and provided attor indicated: 14. Outdated, is continued or	F0425	Element # 1What corrective action(s) will be accomplishe those residents found to have been affected by the deficent practice? It is the policy of this facility to see that routine, emergency drugs, and biolog are available to the residents per the resident's need/physi order. All of this is available through an agreement with a licensed pharmacist. The pharmacy will provide monitor and consultation. This include checking dates on drugs for expiration. Currently all Novol	e t t s gicals s as ican oring des		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	COMPL	
		155298	B. WIN	NG		07/19/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF	ROVIDER OR SULLEL			8530 TO	OWNSHIP LINE RD		
		SING & REHABILITATION CENT	ER ———		APOLIS, IN46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	1	noved from stock"			insulin is not used past the 2 expiration period (after	8 day	
	A current facility	policy dated 10/07 and			opening).Element # 2How of	hor	
	titled, "Medicati	ons with Special			residents having the potentia		
	Expiration Date	Requirements" and			be affected by the same defi		
	provided by the	administrator indicated,			practice will be identified and		
	1 ^	expire opened, 28 days."			what corrective action(s) will	be	
	Trovolog viais	inpire openeu, 20 days.			taken?Any residents on Nov		
	Observation of t	he medication cart on the			insulin has the potential to be		
					affected by this finding. The	DON	
		fall on 7/18/11 at 10:30			or designee will check all medication carts at least onc	· _	
		n open vial of Novolog			weekly for residents on Nove	_	
	(insulin) dated 6	/16/11.			insulin to be sure it is dated	-	
					opened and is not used after	r a 28	
	Observation of t	he medication cart on the			day period. This monitoring	will	
	3rd floor North 1	Hall on 7/18/11 at 10:30			continue until 4 consecutive		
		n open vial of Novolog			weeks of zero negative finding		
	(insulin) dated 6	-			are realized. Afterwards, ran		
	(msum) dated 0	/1//11.			checks will be made. Elemen 3What measures will be put		
		d I DNI 110 - 7/10/11			place or what systemic chan		
		th LPN #8 on 7/18/11 at			will be made to ensure that t	-	
		cated open insulins expire			deficent practice does not		
	after 28 days.				reoccur?At an all staff inserv	rice	
					held 8/9/11 the fact that som	е	
	3.1-25(o)				medications have a specific		
					amount of days they can be		
					after they are opened will be discussed. Futher, the fact t		
					medications which need to b		
					opened must also be dated		
					reviewed. Any staff who fail	to	
					comply with the points of this	6	
					inservice will be further educ		
					and/or progressively discipling		
					as appropriate. Also covered this inservice will be the fact		
					no medications are to be	ulal	
					"preset". Medications are to	be	
					prepared or "poured" at the t		
					of administration. Any staff		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 07/19/2011
	PROVIDER OR SUPPLIER	SING & REHABILITATION CENTE	8530 TO	ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
				fails to comply with the point this inservice will be further educated and or progressive disciplined as appropriate. Element # 4How corrective action(s) will be monitored to ensure the defi practice will not reoccur, i.e. quality assurance program who put into place; At the month Quality Assurance meetings monitoring of Novolog insulicentiates by the DON or design will be reviewed. Any conceivable be corrected as found. However, any patterns will be identified and any needed education will be done by th DON or designee as found the needed.	ely  the  cient , what vill be ly the n nee erns e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155298 07/19/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8530 TOWNSHIP LINE RD CAMBRIDGE MANOR NURSING & REHABILITATION CENTER INDIANAPOLIS, IN46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must employ or obtain the services F0431 of a licensed pharmacist who establishes a SS=E system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked. permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Element # 1What corrective Based on observation and interview F0431 08/18/2011 action(s) will be accomplished for the facility failed to ensure those residents found to have medications were labeled with open been affected by the deficient dates for 2 of 5 medication carts practice?It is the policy of this checked for open dates and failed to facility to see that a pharmacy is working to provide services to the ensure controlled (narcotic) facility to meet the needs of the medications were not preset for 1 of 5 residents for any ordered drugs or medication carts checked for preset

biologicals. Curently, all

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	OF CORRECTION	155298		LDING	00	07/19/2	
		100200	B. WIN			0771072	
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
CAMBRIDGE MANOR NURSING & REHABILITATION CENTER			ER		DWNSHIP LINE RD APOLIS, IN46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPRO	re	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	medications.		İ	İ	medications opened before ι	ıse	
					at the facility are dated as to		
	Findings include	de:			opened date and destroyed t	•	
	Timumige moral	.0.			per opened medication policy		
	Λ current facilit	ty policy dated 10/07			Further, no ordered narcotics any other medications are	s nor	
					present prior to actual		
		edication Storage" and			adminstration.Element # 2Ho	)W	
	1 '	e Administrator on			other residents having the		
		A.M. indicated,			potential to be affected by the		
		12Date insulin			same deficient practice will b		
	vials when first	•			identified and what corrective	9	
	2. Controlled	d medications must be			action(s) will be taken?All residents have the potential	to bo	
	1	ely from non-controlled			affected by this finding. Goir		
	medications."				forward the DON or designed	•	
	A current facilit	ty policy dated 10/07			monitor all medication carts		
	and titled, "Me	dication Administration"			least once weekly for resient	s on	
	and provided b	by the Administrator on			Lantus insulin to be sure it is		
	1	A.M. indicated,			dated when opened and is n		
	Medication A	•			used past the expiration period		
		s are administered in			for opened medications. Thi monitoring will continue until		
		th written orders of the			consecutive weeks of zero	7	
	Prescriber	an written orders of the			negative findings are realized	d.	
	4. Medicatio	no are to be			Afterwards, random weekly		
					checks will be made. Also, d	uring	
		t the time they are			this monitoring the DON or		
	prepared.				designee will also check to s that no medications are "pres		
					prior to their actual	o <del>c</del> l	
		the medication cart on			administration. This monitor	ina	
		orth Hall on 7/18/11 at			will continue until 4 consecut	•	
		ealed 3 vials of Lantus			weeks of zero negative findir		
	(insulin) withoเ	ıt open dates.			are realized. Afterwards, rar	ndom	
					weekly checks will be done.	:111	
	Observation of	the medication cart on			Element # 3What measures		
	the 2nd floor N	lorth Hall on 7/18/11 at			be put into place or what sys changes will be made to ens		
	10:45 A.M. rev	realed 1 vial of Lantus			that the deficient practice do		
	(insulin) withou				not reoccur?At an all staff		
	`	1			inservice held 8/9/11 the fact	that	

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		SING & REHABILITATION CENTE	STREET A 8530 TO	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, IN46260	
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	the 2nd floor Solution 10:45 A.M. reversed a control (Oxycontin) in a top drawer of the During an inter LPN indicated a medication in each	the medication cart on outh Hall on 7/18/11 at ealed LPN # 11 had olled medication a medication cup in the ne medication cart. view at that time, the she had pulled the error for 10:00 A.M. but as not due to get the ill 4:00 P.M.		some medications have a symmount of days they can be after they are opened will be discussed. Futher, the fact medications which need to be opened must also be dated reviewed. Any staff who fail comply with the points of this inservice will be further educand/or progressively discipling as appropriate. Also covered this inservice will be the fact no medications are to be "preset". Medications are to prepared or "poured" at the of administration. Any staff fails to comply with the point this inservice will be further educated and or progressive disciplined as appropriate. Element # 4How corrective action(s) will be monitored to ensure the definition put into place; ?At the month Quality assurance meetings monitoring of opened medicated and not used put their expired number of days be used will be reviewed. Additionally, monitoring by the DON or designee for "presed drugs will be corrected up finding. The DON or design will perform any necessary teaching or progressive disciplines as appropriate.	used e that be was to s cated ned l in that be time who ts of ely v the dicient , what will be ally the ations ast s to